TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
COMBINED CHIROPRACTIC SERVICE

**Respondent Name**
AMERICAN ZURICH INSURANCE CO

**MFDR Tracking Number**
M4-17-2887-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
May 31, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "This was the first evaluation administered, preauthorization is not required on the initial psychological interview."

**Amount in Dispute:** $765.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Note the lack of precert/preauth raised as a defense."

**Response Submitted by:** Flahive, Ogden & Latson

## *SUMMARY OF DISPUTED SERVICE(S)*

| Date(s) of Service | Disputed Service(s) | Amount In Dispute | Amount Due |
|---|---|---|---|
| June 9, 2016 | 90791 | $765.00 | $206.44 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

### Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/ notification absent.
   - W3 –This bill has been identified as a reconsideration or appeal
   - 16 – Claim/service lacks information or has submission billing error() which is needed for adjudication

## Issue(s)

1. Does CPT Code 90791 require preauthorization?
2. Is CPT Code 90791 a timed procedure code?
3. Is the requestor entitled to reimbursement?

## Findings

1. The requestor seeks reimbursement for CPT code 90791 rendered on June 9, 2016. The insurance denied the disputed service with payment reduction codes, "197 – Precertification/authorization / notification absent."

   28 Texas Administrative Code §134.600(p)(7) states, "Non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program..."

   CPT code 90791 is defined as "Psychiatric diagnostic evaluation."

   The requestor indicates in their position summary the following, "This was the first evaluation administered, preauthorization is not required on the initial psychological interview."

   Review of the insurance carrier's response, contains insufficient documentation to support that the disputed services is a "repeat interview." As a result, the insurance carrier's denial reason is not supported and the disputed service is reviewed pursuant to the applicable rules and guidelines.

2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 Texas Administrative Code §134.203 (b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   CPT code 90791 is defined as "Psychiatric diagnostic evaluation."

   A review of the submitted billing and medical records finds that the requestor billed for three (3) units of CPT Code 90791. CPT code 90791 is not defined as a timed procedure. Based on the code descriptor and the submitted report, one unit is recommended for reimbursement.

3. Per 28 Texas Administrative Code §134.203(c) (1) (2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   CPT Code 90791 rendered on June 9, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 3 multiplied by the geographic practice cost index (GPCI) for work of 1 is 3. The practice expense (PE) RVU of 0.59 multiplied by the PE GPCI of 0.92 is 0.5428. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.822 is 0.09042. The sum of 3.63322 is multiplied by the Division conversion factor of $56.82 for a MAR of $206.44. Therefore this amount is recommended.

   The Division finds that the requestor is entitled to reimbursement in the amount of $206.44 for CPT Code 90791. As a result, this amount is recommended.

## Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $206.44.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $206.44 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

## Authorized Signature

| | | |
|---|---|---|
| | | June 23, 2017 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.